UF UNIVERSITY of FLORIDA

College of Medicine - *Jacksonville*

Office of Educational Affairs

EXTERNAL ROTATION REQUEST FORM

Requests must be received no less than 120 days before the anticipated start date.

Resident Name: _____

Email: _____

Current Institution: _____

Current Program: _____

Year in Program: _____

Rotation requested: _____

❑ Goals and Objectives for requested rotation ARE attached.

Send application form and non-refundable $25.00 fee to this address. If you would like to pay via credit card please call 904-244-3149:

UFCOM-J Office of Educational Affairs (OEA)
653-1 West 8th Street
4th Floor, LRC Box L15
Jacksonville, FL 32209

Preferred rotation dates (mm/dd/yy to mm/dd/yy)

1st choice: _____

2nd Choice: _____

_____ _____

Resident Signature Date

EXTERNAL RESIDENT'S PROGRAM DIRECTOR AND MALPRACTICE COVERAGE INFORMATION

Program Director Name: _____

E-Mail Address: _____

Address: _____

Phone: _____

During the resident's participation in the rotation, the following professional liability (PL) coverage is in effect: (**Must Select One**)

_____ **Trainee is an employee/agent of one of the following Florida state universities and is protected under the respective university's PL self-insurance program, or is a military resident/fellow and covered under the FTCA:**

- O University of Florida
- O Florida State University
- O Florida Atlantic University
- O University of Central Florida
- O Florida International University
- O Military

-OR-

_____ While engaged within course and scope of this rotation, Trainee shall function in the capacity of an employee or agent of the University of Florida Board of Trustees (UFBOT) and shall be subject to the personal immunity to tort claims as described in Section 768.28, Florida Statutes. Accordingly, the UFBOT shall, in accordance with applicable Florida laws and regulations, provide professional liability protection for claims and actions arising from the clinical activities of Trainee. Trainee/Institution agrees to pay a contribution in the amount of $_____to the UFBOT's self-insurance program, the basis of which shall be the proration of the annual specialty charge for a similar resident or fellow employed by the UFBOT. **The check should be made payable to the UF Self-Insurance Program and sent to the following address prior to the rotation start date: UF Self-Insurance Program, PO Box 112735, Gainesville, FL 32611-2735.** Nothing herein is intended to serve as a waiver of sovereign immunity by the UFBOT and/or the Florida Board of Governors. Nothing herein shall be construed as consent by a state agency, public body corporate, or political subdivision of the State of Florida to be sued except as permitted by Section 768.28 Florida Statutes.

My signature below indicates the trainee is in good standing and has malpractice coverage as indicated above. When residents train at UF Health Jacksonville, the resident is claimed for that training time on the UF Health Jacksonville cost report.

_____

APPROVED: Program Director Signature Date

NOTE: OEA staff will obtain department approval and confirm the approved rotation dates via e-mail. Additional information will be requested at that time.